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No. 97-689

IN THE

Supreme Court of the United States

OCTOBER TERM, 1997

BONNIE L. GEISSAL, as representative of the estate of JAMES W. GEISSAL, deceased,

Petitioner,

v.

MOORE MEDICAL CORP., GROUP BENEFIT PLAN OF MOORE MEDICAL CORP. and HERBERT WALKER,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Eighth Circuit

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BRIEF OF THE HEALTH INSURANCE ASSOCIATION OF AMERICA AS *AMICUS CURIAE* IN SUPPORT OF RESPONDENTS

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BRIEF OF THE HEALTH INSURANCE ASSOCIATION OF AMERICA AS *AMICUS CURIAE* IN SUPPORT OF RESPONDENTS

The Health Insurance Association of America respectfully submits this brief as *amicus curiae* in support of the respondents, Moore Medical Corp., Group Benefit Plan of Moore Medical Corp. and Herbert Walker (collectively the "Plan").1/ Both petitioner and respondents have consented to the filing of this brief. Letters reflecting those consents have been filed with the Clerk of this Court.

INTEREST OF *AMICUS CURIAE*

The Health Insurance Association of America ("HIAA"), based in Washington, D.C., is one of the largest associations of health insurance companies in the world. HIAA is an advocate for the private, market-based health insurance system. Its more than 200 members provide medical expense and supplemental insurance, as well as long-term care insurance and disability income protection to more than 65 million Americans. HIAA develops and advocates federal and state policies which build upon our health care system's quality, affordability, accessibility and responsiveness.

To fulfill its mission, HIAA develops and advocates policy positions that will improve the health care financing

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1/ No counsel for any party in this case authored this brief, either in whole or in part. No person or entity other than HIAA has made a monetary contribution to the preparation or submission of this brief.

system. HIAA represents the interests of its members in both public and private forums. Where critical issues are involved, HIAA seeks to advance the interests of the health insurance industry (and the 65 million Americans who depend on HIAA's members for their health insurance coverage) by participating as *amicus curiae* in cases pending before federal and state courts. Because HIAA's members will be directly affected by the Court's interpretation of the "continuation coverage" provision at issue here, HIAA has a strong interest in the outcome of this case.

The sections of the Consolidated Omnibus Budget Reconciliation Act of 1986 ("COBRA"),[2] that amended the Employee Retirement Income Security Act ("ERISA"), codified at 29 U.S.C.A. §§ 1161-1169 (West Supp. 1998),[3] require both insured and self-insured employer-sponsored group health plans to offer temporary continuation coverage to qualified beneficiaries who would otherwise lose group healthcare eligibility. If the qualified beneficiary elects coverage, the employer must continue to provide coverage until a terminating event occurs.[4]

2/ Pub. L. No. 99-272, 100 Stat. 82 (1986).

3/ The COBRA amendments to ERISA will hereinafter be referred to generally as "COBRA".

4/ The provision at issue here permits termination of coverage on:

> [t]he date on which the qualified beneficiary first becomes, after the date of the election --
>
> (i) covered under any other group health plan (as an employee or otherwise) which does not contain any

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For self-funded group health plans, the financial burdens of providing continuation coverage can be enormous. For insurers underwriting the risks for group health plans and the employers they insure, the requirements of COBRA are costly and create actuarial difficulties. At the same time, COBRA ensures that qualified beneficiaries and their eligible dependents have access to health care during a period of unemployment. Where a qualified beneficiary enjoys dual coverage under a spouse's employer-sponsored group health plan, the administrative and cost burdens that COBRA would otherwise impose on the qualified beneficiary's group health plan are not warranted.

For that reason, and for the reasons discussed below, COBRA should not be expanded beyond its intended scope. Accordingly, HIAA urges the Court to uphold the Eighth Circuit's finding that "[t]he Plan did not violate COBRA when it terminated [James Geissal's] continuation insurance coverage." *Geissal v. Moore Medical Corp.*, 114 F.3d 1458, 1467 (8th Cir. 1997), *reprinted in* the Appendix to the Petition for Certiorari ("Pet. App.") at A-1-A-18.

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> exclusion or limitation with respect to any preexisting condition of such beneficiary . . .

29 U.S.C.A. § 1162(2)(D)(i).

SUMMARY OF ARGUMENT

The Eighth Circuit correctly found that preexisting coverage under a spouse's group health plan is a terminating event pursuant to 29 U.S.C.A. § 1162(2)(D)(i). That finding is consistent with the language of the statute, rules of statutory construction, and common sense.

Because there are two competing interpretations of the relevant provision of the statute, the court below properly turned to the legislative history. That legislative history clearly shows that Congress intended COBRA to provide "continued access to affordable private health insurance" for Americans who would otherwise be "without *any* health insurance coverage" due to loss of employment, divorce or the death of a parent or spouse. *See* Report To Accompany Recommendations From The Committee on Education and Labor, H.R. Rep. No. 99-241, 308 (1985), *reprinted in* 1986 U.S.C.C.A.N. 42, 959 (emphasis added). Nothing in the legislative history indicates that Congress intended to provide for the continuation of dual coverage. Consequently, the Eighth Circuit's interpretation must be adopted because it is the interpretation that is most harmonious with the language, scheme and purpose of the statute. It also serves the public interest by protecting those who need coverage the most (i.e., those who would otherwise have no insurance) without placing undue burdens on employer-sponsored group health plans.

The Eighth Circuit's "Significant Gap" Analysis Must Be Rejected Because It Is Not Supported By The Statute. After properly finding that coverage under a preexisting group health plan constitutes "other" coverage pursuant to 29 U.S.C.A. § 1162(2)(D)(i) (Pet. App. at A-11-A-12), the court below turned to the issue of whether James Geissal's preexisting plan contained a "significant gap" in coverage. Pet. App. at A-12. The purpose of that analysis was to determine whether the preexisting plan should be exempted

from the general rule that coverage under "any other group health plan" bars continuation coverage under COBRA.

The plain language of § 1162(D)(2)(i) sets forth only one exception to the "other plan" termination provision. That exception applies to plans that limit or exclude coverage for a preexisting condition of the qualified beneficiary.[5/] The Eighth Circuit, however, did not limit its "significant gap" analysis to a determination of whether a "gap" in coverage is caused by an exclusion or limitation based on a preexisting condition of the beneficiary. *See* Pet. App. at A-13-A-15. Instead, the court embraced an expansive, judge-made rule that is nearly impossible to apply at the administrative level. Although the Eighth Circuit's analysis did not affect the outcome of this case, it creates administrative burdens and uncertainties for employers and plan administrators. If unchecked, the analysis will result in increased litigation and higher health care costs. Therefore, the "significant gap" analysis should be limited to the terms of the statute.

Public Policy Considerations Support HIAA's Interpretation Of The Statute. The claims and administrative costs of COBRA are making premiums impossible to afford. Consequently, self-insured and smaller employers who are unable to absorb the volatile risks of COBRA continuation coverage may have to cease offering group health plans altogether. Therefore, it is in the interest of the public that

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5/ As discussed *infra* at Section IIA, preexisting condition exclusions may not extend for a period of more than 12 months (18 months in the case of a late enrollee). In most cases, the exclusionary period is less. If the exclusionary period under the other plan has already expired, the termination provision would apply.

COBRA coverage be available only to qualified beneficiaries who would not otherwise be covered by a group health plan.

BACKGROUND

Each year since 1991, a comprehensive study of employers and group health plan administrators has been conducted to determine the impact of COBRA continuation coverage on employer-sponsored group health plans.[6/] The most recent survey was completed in the spring of 1997 and represents the experience of 199 employers providing ERISA health plan benefits to 1.42 million workers, 80% of whom were group health plan participants.[7/]

The 1997 COBRA Survey demonstrates the following: (1) claims costs for COBRA continuees averaged 156% of costs for active employees;[8/] (2) approximately 35% of the total costs of continuation coverage was borne by employers;[9/] (3) COBRA costs bear no practical relationship to active employee health plan costs and vary widely from benefit year to benefit year, making it impossible for employers to predict

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6/ *See* Charles D. Spencer & Associates, Inc., *1997 COBRA Survey: More Than One In Four Elect Coverage, Cost Is 156% of Active Employee Cost*, published by Spencer Research Reports on Employee Benefits, 329.04 (August 22, 1997) (hereinafter "1997 COBRA Survey").

7/ 1997 COBRA Survey, 329.04.-1.

8/ 1997 COBRA Survey, 329.04.-3.

9/ *Id.*

and budget for COBRA risks;[10/] (4) administrative costs for COBRA average $276.36 per participant annually;[11/] (5) less than one percent of COBRA continuees convert to individual health insurance policies;[12/] and (6) the average length of coverage for an 18 month qualifying event was 11.9 months, the highest in the last six years.[13/]

In addition, the 1997 COBRA Survey identified five primary difficulties in administering continuation coverage: (1) collecting premium payments; (2) managing the record-keeping burdens associated with continuation coverage; (3) becoming notified and notifying qualified beneficiaries of COBRA eligibility and changes; (4) managing the cost of coverage; and (5) complying with what the surveyed employers perceive as vague and unreasonable provisions of the law.[14/] The survey noted that these five problems have been identified as primary concerns of survey respondents during each of the last six years.[15/] Given these facts, HIAA and its members seek relief from the Eighth Circuit's unfounded (and wholly unnecessary) "significant gap" analysis.

10/ 1997 COBRA Survey, 329.04.-4 - 5.

11/ 1997 COBRA Survey, 329.04.-5.

12/ 1997 COBRA Survey, 329.04.-6.

13/ Coverage for a 36-month qualifying event averaged 21.3 months. *Id.*

14/ 1997 COBRA Survey, 329.04.-2 - 3.

15/ 1997 COBRA Survey, 329.04.-2.

ARGUMENT

I. THE EIGHTH CIRCUIT CORRECTLY HELD THAT A QUALIFIED BENEFICIARY IS NOT ENTITLED TO CONTINUATION COVERAGE UNDER COBRA IF HE OR SHE IS COVERED UNDER A PREEXISTING GROUP HEALTH PLAN.

The Eighth Circuit's finding that preexisting coverage under a spouse's group health plan is a terminating event pursuant to 29 U.S.C.A. § 1162(2)(D)(i) is supported by the principles of statutory construction. Although statutory construction begins with the language of the statute itself, the underlying rule of construction is to effect the will of Congress. In enacting COBRA, Congress did not intend to guarantee dual coverage for a subset of persons. Rather, Congress intended to guarantee coverage for persons who would otherwise not be covered by any group health plan.

A. The "Plain Meaning" Rule Does Not Apply Because The Language Of The Statute Is Ambiguous.

Geissal and *amici* American Association of Retired Persons ("AARP") and National Employment Lawyers Association ("NELA") argue that the COBRA termination provision is unambiguous. They contend that § 1162(2)(D)(i) is susceptible to but one reading: only group coverage that is obtained after the date of election can terminate an employee's COBRA rights. Petitioner's Brief ("Pet. Brief") at 19; AARP/NELA Brief at 6. This interpretation of the continuation coverage provision focuses on the phrase "first becomes, after the date of election."

However, the words of a statute cannot be read in isolation, but must be considered in the context in which they are written. *Deal v. United States*, 508 U.S. 129, 132 (1993).

See also Conroy v. Aniskoff, 507 U.S. 511, 515 (1993) (Statute must be read as a whole).

By its very terms, COBRA represents a balancing of interests.16/ Its continuation provisions provide qualified beneficiaries of group health plans a transitional period during which they may continue their group health coverage while seeking to replace it. Its limitations, exclusions and termination provisions, on the other hand, confine the burdens that COBRA imposes on employers, and their group health plans.17/

Consequently, the court below correctly held that the phrase "first becomes, after the date of election" is not meant to insulate persons who are covered by preexisting insurance from the termination provision. Pet. App. at A-12. Rather, it signifies that "it is only *after* the election date that an employee's status as beneficiary under another group health plan will permit termination of COBRA benefits." *Id.* The Eighth Circuit's interpretation gives effect to the plain meaning of COBRA in a manner that reconciles all of its provisions.18/

16/ *Compare*, 29 U.S.C.A. § 1161 (mandating that continuation coverage be provided to certain individuals) *with* § 1162(2) (defining the circumstances under which continuation coverage may be terminated).

17/ *See, e.g.*, 29 U.S.C.A. § 1162(2)(A) (providing a maximum period for which benefits must be continued).

18/ Because COBRA provides a 60-day election period (29 U.S.C.A. § 1165), the phrase "after the date of election" protects qualified beneficiaries who lose dual coverage before their election date. It also permits beneficiaries who are covered by a preexisting plan to terminate the preexisting plan

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In particular, the Eighth Circuit found the following rationale of the Eleventh Circuit in *Nat'l Cos. Health Benefit Plan v. St. Joseph's Hosp. of Atlanta, Inc.*, 929 F.2d 1558, 1570 (11th Cir. 1991), persuasive:

> [I]t is immaterial when the employee acquires other group health coverage; the only relevant question is when, after the election date, does that other coverage take effect. In the case of an employee covered by preexisting group health coverage, the terminating event occurs immediately; the first time after the election date that the employee becomes covered by a group health plan other than the employer's plan is the moment after the election date. In effect, such an employee is ineligible for continuation coverage.

Pet. App. at A-9-A-10. Consequently, Geissal's interpretation of the statute is not the only construction that gives meaning to its terms.

Geissal's argument that the statute is unambiguous is further belied by the fact that well-informed persons have read the text differently. Several courts (including three courts of appeals) and the Treasury Department[19/] have interpreted COBRA's continuation coverage provision to permit the termination of continuation coverage where the beneficiary had

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before the election date if they determine that the COBRA plan is more beneficial.

19/ The Treasury Department is authorized by Congress to promulgate COBRA insurance regulations. *Cf.* 29 U.S.C.A. § 1168.

preexisting coverage under another group health plan.[20/] Because there is no consensus on the plain meaning of the statute, Geissal's argument that it is unambiguous, must fail.[21/]

B. The Eighth Circuit's Interpretation Of The Continuation Coverage Provision Must Prevail Because It Is The Construction That Most Fully Promotes The Purpose Of The Statute.

When there is more than one possible reading of a statute, the Court's duty is "to find that interpretation which can most fairly be said to be imbedded in the statute, in the sense of being most harmonious with its scheme and with the general purposes that Congress manifested." *Comm'r of Internal Revenue v. Engle*, 464 U.S. 206, 217 (1984) (*quoting NLRB v. Lion Oil Co.*, 352 U.S. 282, 297 (1957)).

Geissal argues that "[t]he legislative history of the continuation of coverage provisions in COBRA is very sparse and generalized. . . . As a result, most of what one finds when attempting to discern the legislative intent behind various statutory passages from extrinsic materials are pontifications by Congressional Committees in after-the-fact reports." Pet. Brief at 40-41. Although the legislative history is scant, it shows

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20/ *See* Brief of *amicus* United States ("U.S.") at 14 (stating that the Internal Revenue Service's ("IRS") 1987 proposed regulation endorsed the view adopted by the Fifth, Eighth and Eleventh Circuits). *See also*, 52 Fed. Reg. 22716, 22730 (Proposed Rules of the IRS, Dep't. of Treasury).

21/ The recent decision of the IRS to endorse Geissal's interpretation as the "better interpretation" (Brief of U.S. at 14-15), effectively illustrates that the provision is subject to two constructions.

COBRA continuation provisions were intended to provide "continued access to affordable private health insurance" for Americans who would otherwise be "without *any* health insurance coverage" due to loss of employment, divorce or death of a parent or spouse. Report To Accompany Recommendations From The Committee on Education and Labor, H.R. Rep. No. 99-241, 308 (1985), *reprinted in* 1986 U.S.C.C.A.N. 42, 959 (emphasis added). *See also* Finance Committee Reconciliation Report, S. Rep. No. 99-146, at 363 (1985), *reprinted in* 1986 U.S.C.C.A.N. 42, 322 ("The committee was concerned that certain spouses and dependent children may be *deprived* of health benefits due to an unexpected change in family status.") (emphasis added); H.R. Rep. No. 99-241, at 44 (1986), 1986 U.S.C.C.A.N. 42, 622.

Thus, the Eighth Circuit's holding that preexisting coverage under a spouse's group health plan is a terminating event pursuant to 29 U.S.C.A. § 1162(2)(D)(i) is consistent with the purpose of the statute. By contrast, Geissal's interpretation lacks support in the legislative history. It is based on an assumption that Congress intended to preserve the status quo for all individuals, including those who were covered under another group health plan.[22/] Neither the

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22/ *Amici* AARP and NELA rely on 29 U.S.C.A. § 1162(1) to support the position that Congress intended to preserve the beneficiary's status quo. AARP/NELA Brief at 10. Geissal does so indirectly by relying on *Lutheran Hosp. of Ind. v. Bus. Men's Assurance Co. of America*, 51 F.3d 1308 (7th Cir. 1995), which, in turn, depends on § 1162(1). *See* Pet. Brief at 34 (*citing Lutheran Hosp.*, 51 F.3d at 1313). Section 1162(1) requires that continuation coverage be "identical to the coverage provided . . . to similarly situated beneficiaries [for] whom a qualifying event has not occurred." It also provides

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legislative history nor the policies behind the statute, however, support such a finding.[23/] Therefore, the Eighth Circuit's interpretation, not Geissal's, must prevail.

II. THE EIGHTH CIRCUIT'S "SIGNIFICANT GAP" ANALYSIS MUST BE REJECTED.

A. A "Significant Gap" is Only Created Where There are Limitations or Exclusions on Coverage for Preexisting Conditions.

As stated above, the goal of Congress in enacting COBRA was to protect uninsured Americans. Prior to 1989, the statute permitted continuation coverage to be terminated on:

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that, if coverage is modified for other plan beneficiaries, it "shall also be modified in the same manner" for the qualified beneficiaries. § 1162(1). That section does not protect the status quo for individuals with preexisting coverage. Rather, it insures that qualified beneficiaries electing COBRA receive the same quality of benefits as other beneficiaries in the same plan.

23/ In opposition to a 1995 proposal to eliminate the mandatory minimum period during which employers must offer continuation coverage under COBRA, Rep. Archer stated that "The intent of the COBRA continuity provisions . . . is to offer a transitional benefit for employees and their dependents when they lose health coverage as a result of a qualifying event. . . . Extending COBRA continuity beyond its intended purpose would not only increase health care costs for employers and employees, but may even make coverage unaffordable for some employers now offering coverage." 141 Cong. Rec. H1912-06, H1951-52 (daily ed. Feb. 21, 1995). Similarly, expanding the requirement of continuation to preserve dual coverage may have the same negative effects.

> [t]he date on which the qualified beneficiary first becomes, after the date of the election --
>
> (i) covered under any other group health plan (as an employee or otherwise).

29 U.S.C.A. § 1162(2)(D)(i) (1986). Congress recognized that, where a qualified beneficiary is covered by another plan and that plan excludes coverage for preexisting conditions, that individual is uninsured for a preexisting condition during the period of exclusion. *Cf.* H.R. Rep. No. 101-247, reprinted in 1989 U.S.C.C.A.N. 1906, 1943. Therefore, Congress amended § 1162(D)(2)(i) to preclude termination of continuation coverage based on the beneficiary's coverage under another health plan if the other plan contains an "exclusion or limitation with respect to any preexisting condition of such beneficiary."

The statute now states that continuation coverage may be terminated on:

> [t]he date on which the qualified beneficiary first becomes, after the date of the election --
>
> (i) covered under any other group health plan (as an employee or otherwise) which does not contain any exclusion or limitation with respect to any preexisting condition of such beneficiary
> . . .

29 U.S.C.A. § 1162(2)(D)(i) (West Supp. 1998).

The preexisting condition limitation is the only exception to the "any other group health plan" termination provision set forth in § 1162(D)(2)(i). Hence, the only exclusion recognized in the statute is for plans that contain exclusions or limitations based on a preexisting condition of the beneficiary. Accordingly, the only determination that needs

to be made is an objective one: whether the preexisting (or newly acquired) group health plan contains limitations or exclusions relating to a preexisting condition of the beneficiary and, if so, whether the exclusionary period is still in effect.[24/] If the policy does not limit the beneficiary's coverage for a preexisting condition, COBRA continuation rights under the employer's plan may properly be terminated.

The Eighth Circuit nevertheless adopted a test that would require plan administrators and courts to examine the two policies "to determine their benefits, whether there is any exclusion or limitation on the patient's preexisting condition, and with a view to the treatment that the beneficiary may forseeably require." Pet. App. A-14 (*quoting Lutheran Hosp.*, 51 F.3d at 1318 (Coffey, J., dissenting)). In the instant case, the Eighth Circuit considered, *inter alia*, the difference in yearly deductibles and lifetime maximums on benefits. It concluded that these differences did not amount to a

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24/ In 1996, Congress enacted the Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104-191, 110 Stat. 1936 (1996)), codified at 29 U.S.C.A. § 1181-1191c. (West Supp. 1998) as an amendment to ERISA. Section 1181(a)(2) limits the period for which a group health plan may impose a preexisting condition exclusion or limitation. Such exclusions may not extend "for a period of more than 12 months (or 18 months in the case of a late enrollee) after the enrollment date."

For purposes of § 1181, a "preexisting condition exclusion" is defined as "a limitation or exclusion of benefits relating to a condition *based on the fact that the condition was present before the date of enrollment.*" § 1181(b)(1)(A) (emphasis added).

"significant gap in coverage." *Id.* This depth of analysis, however, is not required by the statute.25/

In enacting COBRA, Congress provided a general mechanism by which qualified beneficiaries could obtain transitional insurance coverage at group plan rates. Were Congress concerned with the specific costs to the beneficiary, such as copayments, deductibles and premiums, it could have regulated these charges, or it could have defined the terms of replacement coverage.

The confusion regarding what constitutes a "gap" is created by the inappropriate focus on the differences in specific terms and obligations of the policies under comparison. The fact that Congress did not intend the focus to be on such

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25/ The term "significant gap" does not appear in the statute. It was borrowed from the legislative history, which states that the 1989 amendment was:

> "intended to carry out the original intent of the health care continuation rules, which was to reduce the extent to which certain events, such as the loss of one's job, could create a significant gap in health coverage. If a qualified beneficiary is covered under another plan that excludes coverage for a preexisting condition, he or she is at risk during the period of exclusion."

H.R. Rep. No. 101-247, reprinted in 1989 U.S.C.C.A.N. 1906, 1943. As the amendment itself shows, Congress was concerned with a "gap" resulting from a preexisting condition, not the indefinite number of gaps contemplated by the Eighth Circuit's analysis.

differences is demonstrated by the word "any" in the phrase "any other group health plan." *See* § 1162(2)(D)(i). The impropriety of focusing on discrete differences between plans is further supported by Congress' enactment of § 1162(2)(D)(ii). That section permits the termination of COBRA coverage when a qualified beneficiary becomes entitled to Medicare benefits. Compared to most group health plans, Medicare offers limited benefits.26/ For example, Medicare does not provide coverage for prescription drugs. Yet, that is a common benefit provided by most group health plans.

The appropriate focus, which Congress intended, is upon the potential for loss of coverage due to the beneficiary's preexisting condition. Thus, under the terms of the statute, the so-called "gap" is simple to discern: it is an exclusion or limitation contained in the replacement policy regarding preexisting conditions. Any other purported "gap," such as a discrete difference in benefits or a difference in copayment or deductible requirements, is not a cognizable difference under COBRA. Such "gaps" should not have been considered by the Court below.

B. The "Significant Gap" Analysis Adopted By The Eighth Circuit Is Unworkable, Puts Plan Administrators At Risk And Results In Increased Costs To Plans And Plan Beneficiaries.

HIAA and the *amici* who support petitioner herein agree that the Eighth Circuit's "significant gap" test is not only

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26/ *See* 42 U.S.C.A. § 1395d (1992 & West Supp. 1997) (setting forth the Medicare Part A insurance benefits); 42 U.S.C.A. § 1395k (1992 & West Supp. 1997) (setting forth the Medicare Part B supplemental insurance benefits).

contrary to the terms of the statute, but is also unworkable. *See* Brief of U.S. at 13; Brief of AARP/NELA at 12. It requires the plan administrators to analyze the two plans on a benefit-by-benefit basis and to make judgments about an individual's perceived health needs.[27/] It is difficult, if not impossible, to apply and invites costly litigation.

As the court below noted, the detractors of the "significant gap" test have criticized it on the basis that its application will lead to "an inappropriate *post hoc* determination" that gives "little guidance to employers who must decide, on the front end, whether termination of COBRA benefits is warranted." Pet. App. at A-13. In confronting this criticism, the Eighth Circuit developed "a framework which [it believed] is less dependent upon hindsight." *Id.* at A-14. To that end, the Eighth Circuit held that the gap should be measured "by comparing the policies' provisions in light of information available to the employer on the day of the COBRA election." *Id.*

While the Eighth Circuit's analysis provides some guidance, it still lacks the clarity and simplicity that will permit an analysis to be undertaken at the administrative level. Consequently, in many cases, resort to the courts will still be required. In fact, the Eighth Circuit invites this result: "We believe a district court confronted with this question should measure the gap by comparing the policies' provisions in light of information available to the employer on the day of COBRA election." Pet. App. at A-14. *See also id.* ("[T]he court should

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27/ Those decisions are more appropriately made by the qualified beneficiary, who, given a 60-day election period, can decide whether he or she is better off with the COBRA coverage or coverage under another health plan. *See supra* note 18.

examine the policies. . ."). To suggest that the "gap" determination be made by the courts is impractical. It is also unfair to employers and plan administrators due to the significant sanctions which may be assessed against them for violations of ERISA,[28/] including violations of its COBRA requirements.

The Eighth Circuit's "significant gap" test places excessive burdens on employer-sponsored group health plans. It results in an inefficient delivery of health insurance benefits and increased health care delivery costs, thereby negatively impacting the employer-sponsored group health plan benefits system upon which so many millions of Americans depend for their health insurance needs.

In contrast, the construction urged by HIAA is relatively simple to apply. The plan administrators who are required to make the determination of entitlement to continuation coverage need only look for an exclusion based on a preexisting condition and to determine whether that exclusion is currently in effect. Thus, a determination of the applicability of COBRA to a particular situation can be appropriately made by the group health plan administrator, rather than by the courts. This is the only approach that serves both the language of the statute and the Congressional purpose of protecting certain qualified beneficiaries from periods of complete loss of health insurance coverage, while at the same time not over-burdening employer-sponsored group health plans.

28/ *See, e.g.*, 26 U.S.C.A. § 4980B (1989 & West Supp. 1997) (imposing excise taxes); 29 U.S.C.A. § 1132 (1985 & West Supp. 1998) (permitting, *e.g.*, civil enforcement actions by beneficiaries, injunctive actions by the Secretary of Labor, and penalties of up to $100 per day for violations of notice requirements).

III. BECAUSE COBRA PLACES EXCESSIVE BURDENS ON EMPLOYER-SPONSORED GROUP HEALTH PLANS, THE COURT SHOULD AVOID IMPOSING REQUIREMENTS ON GROUP HEALTH PLANS THAT ARE NOT MANDATED BY STATUTE

COBRA coverage for dually-covered individuals is particularly difficult and expensive to administer. It requires the employer or plan administrator to compare both plans to determine whether its coverage is primary or secondary, and to determine whether any special coordination of benefits rules apply.29/ Dual coverage also imposes double administrative burdens on the health care benefits delivery system, increasing costs for all participants. The adoption of the Eighth Circuit's "significant gap" test will only lead to further administrative burdens. Because dually-covered workers are already guaranteed some form of health insurance coverage by another group plan, they need COBRA continuation coverage the least of any group of potentially qualified beneficiaries.

Further, the burdens of dual continuation are disproportionately shifted to (1) employers and plans that absorb a portion of the administrative and claims costs, (2) active employees who may lose all or some of their coverage because their employer can no longer afford to sponsor it, and (3) other qualified beneficiaries who must decline continuation coverage because it has become too expensive. Consequently, the Court should not expand the protections for beneficiaries who are covered by another group health plan to the detriment

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29/ For an indication of the inquiry entailed in a coordination of benefits analysis, see National Association of Insurance Commissioners Group Coordination of Benefits Model Regulation, NAIC 120-1 (April 1997).

of the other plan participants, particularly where Congress has not required such a result.

In sum, COBRA is costly to employers, and its costs may adversely impact the group health plan benefits available to active employees. While these costs may be justified to afford health insurance coverage to those who may otherwise lose it, they are unwarranted in situations where an individual has dual coverage incidental to having a working spouse.

CONCLUSION

For the foregoing reasons, HIAA urges the Court to affirm the decision below and to hold that a qualified beneficiary is not entitled to continuation coverage under COBRA if he or she is covered by a preexisting group health plan unless the preexisting plan contains an exclusion or limitation regarding a preexisting condition of the beneficiary.

Respectfully submitted,

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